DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11016 (Rev. 01/03)

STATE OF WISCONSIN
HFS 107.06(2), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT (PA/PA)

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form. If necessary, attach additional pages if more space is needed. Refer to your service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgement about the case.

Attach the completed Prior Authorization Physician Attachment (PA/PA) to the Prior Authorization Request Form (PA/RF) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services which are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Date of Birth (MM/DD/YYYY)

3. Wisconsin Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name — Performing Provider

5. Performing Provider's Medicaid Number

6. Telephone Number — Performing Provider

7. Name — Ordering / Prescribing Physician

SECTION III — SERVICE INFORMATION

A. Describe diagnosis and clinical condition pertinent to service or procedure requested.

B. Describe medical history pertinent to service or procedure requested.

C. Supply justification for service or procedure requested.

D. SIGNATURE — Physician	Date Signed

Reset Form